COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

IN RE: CHILDREN'S HEALTH TECHNICAL ADVISORY COMMITTEE

March 11, 2020
2:00 P.M.
Cabinet for Health & Family Services
Café Conference Room
275 East Main Street
Frankfort, Kentucky 40601

APPEARANCES

Mahak Kalra
CHAIR

Michael Flynn
Donna Grigsby
TAC MEMBERS PRESENT

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(Continued)

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HUMANA

Sarah Bowling
Chris Bowling
AETNA BETTER HEALTH

Carle Zachodni
ANTHEM

Jessica Beal
Cheri Schanie
PASSPORT

Laura Betten
WELLCARE

Alicia Whatley
KENTUCKY YOUTH ADVOCATES

Elizabeth Anderson-Hoagland
PUBLIC HEALTH

Jerry Caudill
AVESIS

AGENDA

1. Welcome and Introductions

2. Establish Quorum

3. Approval of September, November & January Minutes

4. NEW BUSINESS
   * Presentation from Department of Public Health - E-cigarettes
   * Discussion on requested data from DMS
   * Topics for 2020 meetings
     - Pending: topic ideas - CBD, vaccines, school safety
   * Updates from the MAC
   * Roundtable Updates/concerns from each member/ professional organization

5. OLD BUSINESS:
   * Autism Spectrum Disorder
   * Psychopharmacological prescribing for KY children
   * School-based services and Free-Care Rule
     - Presentation from Alicia Whatley

6. MCO Updates/Questions or Data Request Reporting

7. General governance issues

8. Other Business

9. Action Items

10. Adjourn

MS. KALRA: We can go ahead and get started and do welcome and introductions. Thanks, everyone, for being here. I know there's a lot going on, a lot of different things happening. So, thank you for being here.

(INTRODUCTIONS)

MS. KALRA: So, we clearly don't have a quorum.

DR. GRIGSBY: Will we ever have a quorum again?

MS. KALRA: I would love one. I've been trying.

MS. HUGHES: I have, too.

MS. KALRA: So, I think if members could reach out to other members or at least be active via email so that way it's on top of their radar, that would be great because we have so many things that we need to approve and move forward that we bring to the MAC and we have yet to do that this year and the end of last year.

So, again, anytime you see an email or outreach from us, please respond and at least keep things moving. And if you know any of these individuals well enough, bug them as well.

MS. HUGHES: And if you hear

that they don't want to continue to be on the TAC, let us know and I will reach out to their association.

I don't want to just automatically reach out but if they don't want to participate, and obviously it's up to you all if you want us to, after so many meetings of them not coming, you want to consider having the association assign somebody else who maybe can come because it is bad that you all are not getting a quorum.

MS. KALRA: We want these meetings to be meaningful. That's why they're established so that way we can provide some recommendations to the MAC and make a dent in at least administrative policy.

So, again, that's the importance and goal of this group. So, if we could just encourage our fellow members to be active and engaged so that we aren't wasting our time as well and the drive because I know you both have driven from various parts of the state, I think that would be great.

MS. HUGHES: And before we start into the new business, I can't remember when the last meeting was and if Lisa Lee had already been

appointed.

MS. KALRA: Yes.

MS. HUGHES: Had she already started?

MS. KALRA: I don't think she started yet. It was right before she was about to start, like a week.

MS. HUGHES: Okay. She did want me to let everybody know that she was sorry she wasn't going to be here today but just to remind you all - children are her heart in the Medicaid Program. She was the Kentucky Medicaid KCHIP Director for several years.

So, this is a committee that is probably near and dear to her heart than any other TAC because of her love for children. When she used to be here, she would always go around saying and babies can't help what they've got. They've got to be taken care of. So, she just wanted me to let you know she will be here at the next meeting.

MS. KALRA: That would be great. Thank you.

Let's go ahead and move into New Business. So, on our radar that all the TAC members discussed and mentioned is vaping and vaping

resources and who better to have than Elizabeth to give us all the resources and knowledge. So, I will let you have it from here.

MS. ANDERSON-HOAGLAND: Sure. So, I'm Elizabeth Anderson-Hoagland with the Department for Public Health. I am with Health Promotion but I was the Prevention Coordinator for the Tobacco Prevention and Cessation Program for seven years.

As you know, vaping has come up pretty quickly. It's been something that we've been kind of taking a multi-prong approach. And I apologize I didn't bring more handouts. My kid is actually home sick today, so, I made some handouts and I didn't make other handouts. It's not coronavirus. We checked.

So, I guess the thing - and for those of you work directly with kids, you know this - when we're talking about vaping, we're not talking about a single product, a single device. We're talking about a multitude of devices, and the types of vaping devices that are out there are evolving consistently and constantly.

And if you look at the legislation that has come out or the regulation that

has come out on the federal level, they're clearly playing whack a mole. They're like going after one particular product. They're going after Juul because that's what all the kids were using. We're going to take down Juul.

Well, kids aren't going to stick with Juul if it goes away. They're going to start using a different product. So, now it's Puff Bars. Kids in California are using Puff Bars, these single-use disposal products that look like a Juul, have all the fun flavors that Juul used to have, have all of the strong nicotine content that Juul used to have but they're a disposable product.

MS. KALRA: And they look nice.

MS. ANDERSON-HOAGLAND: And they look pretty. And, so, the federal regulation, in case you all aren't staying on top of the news the same way I am, the federal regulation says that pod-based E-cigarette products cannot be sold in non-tobacco or non-menthol flavors.

So, that means something like a Juul where you have the little pod that you click into the device and you inhale the liquid. That can only be sold in tobacco flavor or menthol flavor.

Why is there a menthol

exemption? Because menthol is really good for initiation of tobacco products. It numbs the throat and numbs your sinus passages, so, you don't notice how harsh the product is and this is true for cigarettes. This is true for smokeless tobacco. This is true for E-cigarettes. So, menthol is good like that.

There's also some research that menthol, the way it activates the brain pathway, is similar to the way nicotine activates some of the brain pathways. So, menthol can actually enhance the impact of nicotine.

So, anyway, at the federal level, they said, well, okay, pod-based Juul, only tobacco, only menthol. So, all of the kids stopped using pod-based products.

So, if you see something like Suorin Drop, that is a refillable pod. So, you take your liquid and you refill the pod and you put the pod in your device and you inhale the liquid. That can come in bubble gum, fruit flavors. That's fine.

Any of the refillable products like the vape pens that you've seen, the big box mods that people use, those that you refill, those can come in any flavor. And, then, of course, the

single-use products like Puff Bar, those can still be sold in any flavor.

So, unless there's comprehensiveness and policy language, you're just going to see kids migrating to another product that still tastes good and still has that amount of nicotine that they're looking for.

So, why do young people use E-cigarettes? This is not an analogy I came up with. This is something Brian King from the CDC came up with. It's like leading a horse to water and making it drink. So, the horse hears about the river. It goes over. It tries the river and, then, it keeps drinking because it's thirsty.

So, if we look at kids with E-cigarettes, they hear about E-cigarettes. They see the advertising. They try the E-cigarette because it comes in bubble gum, it comes in cherry, it comes in fruit, it comes in mint. They're curious and, then, they keep drinking, they keep using the product because of the nicotine.

And what we know is Juul pods have as much nicotine as one to one-and-a-half packages of E-cigarettes. Like, that's the equivalency.

If you look at the Juul knock-off products that you see at the stores, they're coming in even stronger strengths. And, of course, these refillable liquids, they can go stronger and stronger and stronger.

The real revolution that came about with Juul, the reason Juul was so incredibly popular is because the nicotine salts.

The oil types of E-cigarettes you would have free-based nicotine which basically they just like sucked the nicotine out of the tobacco plant, put it in some liquid and you would inhale. You'd have to heat it up and inhale it.

Well, one of the problems was that was really harsh on your throat. The other problem is it didn't absorb very well. So, you needed really high temperatures to get a really good nicotine hit from the free-based nicotine liquid.

What Juul did was create nicotine salts and I don't even know all the chemistry because it's been a long time since I've had chemistry class, but the thing about nicotine salts is they can be a much stronger concentration. They don't hurt your throat in the same way that a free-based nicotine is and they get absorbed into the

brain much faster than free-based nicotine.

So, if you look at nicotine in the blood of someone who is using a Juul E-cigarette, the nicotine in the blood mimics that of what you would get from a conventional cigarette. All of the C-cigarettes are much weaker.

So, when Juul came on the market - and for those of you who have the handout, I have I think it's Slide 4, we have the youth risk behavior survey results for current E-cigarette use.

And, so, what you will see is that in 2015 - that was the first year we asked about E-cigarette use - 23.4%. We said, oh, no, this is a problem. This is like one in five kids are using E-cigarettes.

So, we said, oh, no, a lot of kids are using E-cigarettes. We were concerned about the problem. We started coming up with program to combat the problem.

In 2017, current E-cigarette use dropped to 14% and we're like, oh, good job. We've solved this E-cigarette problem. We have like a 9% decrease in use over two years. That is phenomenal. We're great at this.

Well, of course, then, what

happened is Juul was introduced in 2016/2017. So, if you look at the 2019 youth risk behavior data, it's higher than it's ever been - 26%. One in four youth have said that they are current E-cigarette users, meaning they have vaped in the past thirty days.

I suspect and those of you, again, who work with kids, this is probably an under-representation about how many are currently using C-cigarettes.

So, one of the reasons this is problematic is, of course, how the brain develops and that's one of the reasons why it's difficult to address youth E-cigarette use.

Again, for those of you who work with kids, you know the brain develops from the back of the brain to the front of the brain. The frontal lobe is the last to develop. That's what is in charge of impulse control, long-term planning, decision-making, all of those real good adult skills that you need to successfully quit using because what you have to do if you are addicted to a nicotine product and you have to stop using it, you have to be able to control your impulses not to use. You have to make a plan for what are you going to do when you have a trigger. You have to make a plan for what are

you going to do when you have a craving. Those are all skills that young people really have problems with which is why we have some good cessation resources which I'm going to get to at the end.

The other thing about E-cigarettes and really the industry kind of won the language about E-cigarettes is we call it vaping. We call it water, vaping as in water vapor.

Someone I know does a really great visual with this. When you think water vapor, you're boiling water, you're boiling water for pasta and you inhale that water and you exhale, there's no cloud. There's no cloud because that's what water vapor does. It just dissipates into the air. You don't see it.

However, when you use an E-cigarette and you exhale, there is this giant cloud. That's clearly not water vapor just dissipating into the environment. What we say is that's an aerosol. So, it's small particles and drops of liquid suspended in a gas. So, it's more similar to hair spray than it is to water vapor.

And the person I know, if any of you know Minnie Eckus (sic) at UK, she will take a soda bottle or water bottle, I guess, if you're being

health conscious, and you can put some water in it and show that there's no visible water vapor. Then, you can spray hair spray in there and you can see the hair spray collecting on the sides of the bottles. That's more accurately what's going on with the lungs when it comes to E-cigarette use.

So, what is in the aerosol? Of course, there's the nicotine and there's actually second-hand nicotine exposure from C-cigarette use. You don't inhale all of it into the lungs. You don't absorb all of it in the lungs when you use E-cigarettes. Some of it comes back out.

I'm on this Facebook group talking about home renovations and there is someone in their outside Florida room, well, their semi outside Florida room. The husband was vaping heavily and the walls were turning brown and sticky. Well, that's nicotine. Nicotine is a sticky drug. It's a brown drug. It's sticking to their walls. You've got to clean that off. It's kind of what you would see in a smoker's home.

So, you're clearly exhaling nicotine. You're not absorbing it all when you're using an E-cigarette.

There's ultra-fine particles.

The thing about ultra-fine particles, meaning very, very, very small, they lodge deep into the lungs. So, we know people who use E-cigarettes have a higher risk of heart disease and stroke and heart attack and it's probably due to these ultra-fine particles just because they have been affiliated with heart disease.

There's volatile organic compounds. There's some compounds that are found to cause cancer. If you think about E-cigarettes, if you've ever pulled one apart or looked at one really closely, you have the liquid. You have to heat the liquid up so you're able to inhale it.

Well, they use a little coil to heat that liquid. That coil is made of metal. You heat that metal up to really high temperatures - five, six, seven hundred degrees. You cool it off, you heat it up, you cool it off, you heat it up, you cool it off every time you take a puff. That makes the metal brittle.

So, what are they making these coils out of? Nickel, tin, in some cases lead. So, we know people who use C-cigarettes are getting some of those metal particles into the E-cigarette aerosol.

And, then, there's a lot of

worry about the flavorings used in E-cigarettes. Everyone talks about diacetyl because that's one that we have a lot of data on.

Diacetyl is used in microwave popcorn. It gives it that buttery flavor. It's perfectly safe to eat. It is not safe to inhale because if you inhale large quantities of diacetyl, it causes a type of irreversible lung damage, and I could spell it but I can't pronounce it necessarily. It's like bronchiolitis obliterans or something like that.

And they found it first in popcorn workers. Workers who worked in popcorn plants started getting this lung disease and they finally figured out it was from breathing in the butter flavor.

So, some companies are good about moving away from diacetyl. Juul said that they didn't use it in their creme brulee flavors and stuff like that. Some companies still use diacetyl.

The other thing about flavorings is that E-cigarette companies will say, well, we use generally-recognized safe flavorings. That is a categorization by the FDA about food additives that are generally recognized as safe.

So, if you have something - cinnamon - you add cinnamon to your popcorn, that is generally recognized as safe. Like, it's cinnamon, folks. Like, it's okay to eat that. However, do you want to inhale cinnamon? Absolutely not.

So, some things that are generally recognized as safe for eating are not recognized as safe for your lungs. So, that is a real key distinction that the E-cigarette industry just kind of glosses over.

There is a common talking point for the E-cigarette industry that E-cigarettes are 95% less harmful than cigarettes. And, so, I have a direct quote from the study that is frequently cited.

And the direct quote from the authors is: "A limitation of this study is the lack of hard evidence for the harms of most of the products on most of the criteria."

So, what they are saying here is we don't actually have data about the harms of E-cigarettes, about most of the products on most of the categories that we're looking at. That whole paper, it was just a guess. They were guessing. And, so, that is not something we can base public health on. We can't base public health on a guess.

The other thing to know is let's say E-cigarettes are 95% safer. If you look on Slide 9, this is looking at conventional cigarettes and heart attack risk.

Eighty percent of the risk for heart attack risk comes from three or less cigarettes a day which is why we always say that cutting back is not enough. If you smoke three cigarettes a day, you have 80% the risk of heart attack of someone who is a pack-a-day smoker which is better but it's not good.

So, from a public health perspective, are we willing to say, well, okay, you have 80% of the risk of a heart attack? That's not acceptable from a public health perspective.

And, then, finally, when you're talking about like indoor E-cigarette use or smoke-free policies or indoor air policies, the standard is not is this more or less harmful than secondhand smoke.

The standard is, is this as healthy as clean air? That is the standard we should be basing decisions on, not basing decisions on cigarette smoke because cigarette smoke is one of the most deadly substances known. Like, it kills half of its users.

So, what can you do about it? We currently have three quit lines going in Kentucky. So, the first one - did everyone get one of these handouts?

MS. HUGHES: I don't think I made enough for everybody.

MS. ANDERSON-HOAGLAND: I've got some more, Sharley, because this is good stuff. We currently have three quit lines. Quit Now Kentucky is our longstanding quit line. It used to be for ages 18 and older. Then it was 14 and older. Now we have no age limit. It is the standard quit line. You would call 1/800-QUITNOW or you go to quitnowkentucky.org and you can enroll.

We have a four-call protocol. For anyone over the age of 18 who is uninsured or on Medicare, we provide four weeks of free nicotine replacement therapy through the quit line.

So, the thing is, I think last year, we had six people under the age of 18 enrolled in the traditional quit line. Kids don't want to talk to some adult on the phone. That is not what they're really interested in.

So, we have branched out to two other options. One is My Life/My Quit which was

provided by National Jewish Hospital which provides our quit line. It's for ages 17 and under. It does have talking to adults on the phone but you can also text back and forth with someone back on the phone or you can email someone back and forth on the phone. And, so, that is a five-call protocol.

We also have This is Quitting which will serve anyone ages 13 to 24 but we are really focusing on the 18 to 24 age range. This is an automated text messaging service. So, it's not a live person on the other end. It's automatic text based on how you respond to the program, but this is available for up to nine weeks. So, it's a really long-term service.

This is Quitting is provided by the Truth Initiative and actually has some good evaluation data showing that kids who use this program are quitting.

So, I'm going to leave that with you. I highly encourage you to refer any young people in your life to that.

The final thing I'll say is nicotine replacement therapy, we can give it to people who are over the age of 18. There has been some back and forth about using nicotine replacement

therapy in people under the age of 18 and youth under the age of 18, and it used to be not recommended. If you think about young people, they generally would not smoke on a daily basis.

So, it doesn't make sense to slap a patch on someone who is smoking three days per week because you're giving continuous nicotine as opposed to the intermittent nicotine that they were using before.

However, with the way young people are using C-cigarettes, some of them are very, very heavy users. If you're using two, three, four pods a day, you're not going to be able to quit cold turkey and be all right. You're going to need some nicotine replacement therapy to wean you off of that.

So, nicotine replacement therapy can be prescribed off label to those under the age of 18. You just have to have a doctor who is willing to work with the patient and their parents to make sure that they are using it properly so they can wean themselves off of the nicotine.

The last thing I have on there, and I plopped this on here real quick because in the fall, and actually even today, we're still getting cases of EVALI, the lung injury associated with

vaping. The vast majority of those cases were among people using THC products, though I will say that a third to a half of them were also using nicotine. And, unfortunately, we are still getting cases of people with lung injury associated with vaping.

And, so, I just want to put this out here that there is a way you can find marijuana treatment for those who have difficulty quitting vaping THC.

MS. KALRA: Thank you.

MS. ANDERSON-HOAGLAND: And here's some contact information.

MS. KALRA: Any questions?

DR. GRIGSBY: The Quit Now is the one that has the nicotine replacement program for those over 18?

MS. ANDERSON-HOAGLAND: Yes. We're really not set up to assist with under 18 at this time.

MS. HUGHES: Can I ask a question? You said one pod, I think is what you said, one pod equaled about a pack of cigarettes.

MS. ANDERSON-HOAGLAND: Yes, for Juul, yes.

MS. HUGHES: And how many pods,

are some doing three and four pods a day?

MS. KALRA: Yes.

MS. ANDERSON-HOAGLAND: Yes. Because it's so smooth to inhale and it is so reinforcing and it's so strong, it is very easy for some people to escalate their use.

And you think if you smoke a cigarette, you smoke a cigarette and you put it down. You do something else with your life. That's not how you use an E-cigarette. People are much more intermittent users. You don't have to finish it because it's not burning.

So, if you see someone who is using an E-cigarette, they're walking to another building, they vape the whole way there, they put it in their pocket, they do something for five minutes, they come back out, they vape all the way to the other building, they go do something for twenty minutes, they went outside, they vape a couple of times, they go back in.

So, just the way the nicotine is being used and the way it's reinforcing of the brain is different than the way traditional cigarettes, conventional cigarettes are.

And there seems to be some

research coming out that because of that type of use, youth who use E-cigarettes get addicted faster than youth who use conventional cigarettes.

MS. HUGHES: My neighbor keeps his on one of the badge things around his neck.

MS. ANDERSON-HOAGLAND: Absolutely. That's really common. People, they hold them in their hand all the time.

MS. KALRA: And just as a followup question, too - and correct me if I'm wrong - that's why I'm asking this question - the FDA hasn't approved E-cigarettes as a cessation device.

MS. ANDERSON-HOAGLAND: No. They are not approved as a cessation device. The evidence for cessation is really mixed right now. It's really mixed and we cannot draw any firm conclusions.

MS. KALRA: Michael, I didn't know if you had any stories, you being in the school.

MR. FLYNN: It's interesting. Since our last meeting, the Kentucky Cancer Prevention Center has come to my school and met with us and they've rolled in several programs with us coming in in the next few months.

MS. ANDERSON-HOAGLAND: Which

ones?

MR. FLYNN: I knew you were going to ask that. I sent my secretary a message asking that because I've got it all written down on my calendar but it's all starting in May.

They're doing some classroom presentations with all of our eighth graders. That's where we see the greatest influx between eighth and ninth grade in my district. Lots of high-schoolers are selling hits off their Juul so that they can pay for their own habits, things of that nature.

But, then, they're also doing professional developments for our teachers. There's so many ways that these vaping materials, they all look so different; like, they can hold them in the palm of their hand.

We're finding them tucked into where the drawstring comes through your hoodie. They cut the string out and cut that little hole a little bit bigger and it just looks like they're chewing on their collar and actually they're sitting their vaping the entire time. So, she's bringing in a lot of stuff like that to train our teachers on what to be looking for and things of that nature, just trying to curb the issue.

MS. KALRA: There's Apple watches out there that are vape products that look exactly like my Apple watch.

MS. ANDERSON-HOAGLAND: I've seen one that looked like an asthma inhaler. It's like you think someone is taking their medicine and they're not.

MS. HUGHES: Did they introduce the bill in Session this year to try to ban it from all school properties?

MS. KALRA: That was last year. In 2019, last Session, there was a Tobacco Free School Campus bill and that did pass. So, it should be in effect.

MS. ANDERSON-HOAGLAND: I think there's like two school districts that are holdouts. I think one of them is Madison County, too.

MS. KALRA: So, there's 97% of school districts already complying with that bill. And, then, this year, there's the Tobacco 21 bill which is just making sure that the federal law is codified into state law and, then, also removing status offenses from that as well.

So, that is just waiting to be heard on the House floor. It has made it through all

the other committees and the Senate floor now just one final leg on that. E-cigarette tax is another policy. That actually was in the House budget. It was in the Governor's budget, the House budget and now we're hoping that it's also in the Senate budget.

And, actually, an important note is E-cigarettes are the only tobacco product that isn't taxed currently other than the sales tax that's on it. So, that's why it's important to have an E-cigarette tax.

MR. FLYNN: It's been interesting listening to all the radio campaigns encouraging people to vote against that tax.

MS. KALRA: Oh, really?

MR. FLYNN: You've not heard them?

MS. KALRA: No.

MR. FLYNN: There's one on the radio right now.

MS. ANDERSON-HOAGLAND: Is it the magicvaporshop.com guy?

MR. FLYNN: I think so. It's talking about how legislators are trying to force people into the cancer-causing agents of tobacco by giving up the safe, healthy option of an E-cig. I

mean, that's basically the terminology he's using.

MS. KALRA: I've been in committee rooms where I'm about to testify and every vape shop owner is there. It's really comfortable.

Well, this was helpful because I know this is something that we've all been asking.

Can you send the presentation that you have to us so that way we can get it out?

MS. HUGHES: I have it and I'll also put it online on your all's website.

MS. KALRA: Well, I didn't even know we had a page. So, that's good to know.

MS. HUGHES: Each of the TACs have an individual website. So, we'll put it up there.

MS. KALRA: Thank you. We appreciate you being here and all the resources.

MS. ANDERSON-HOAGLAND: Thank you all very much and my contact information is on there. So, if you all have any questions, any followup, please don't hesitate to contact me. Thank you all very much.

MS. KALRA: Before we move away from this topic, I wonder what the MCOs are hearing as insurance company providers. I'm just interested

in getting that perspective because that's a perspective that we haven't heard from when we hear this. We've heard the physician perspective, the school perspective. So, I don't know if anyone wants to chime in.

MS. BEAL: So, ironically, two years ago, Passport passed on somebody asking us to sponsor using vaping as a preventative or harm-reduction tool but somebody approached us and asked us to pay for that and we said no.

We also have a Health Educator. We have one for one side of the state and one for the other side of the state and they specifically do health education in high schools and middle schools on vaping and that's a free resource.

We have a very lovely handout that I created last year that includes some information on vape, so, it's not your traditional tobacco cessation handout for our members.

And we're working one specific for teens that we're hoping may come with pediatric psychologists that we're going to make a little more teen friendly. We know teens don't generally want to pick something up. So, we're trying to make that a little more appealing to them.

MS. ZACHODNI: And we have similar educational materials, things like that. One of the difficulties, I think, is outreach wise for the teen population in particular. We generally cannot reach out just to the teens. So, we have the ability to text, do all that kind of stuff so we could make the links, but to that conversation under 18, our hands are tied there.

MS. BOWLING: We've got a couple of members in our case management, our pediatric members that will work with the parents on getting them some resources if they have concerns over that. Then we also have a Prevention and Wellness Coordinator that does go do some of those similar presentations.

DR. CAUDILL: I'll say from a dental point of use, the research is showing that are you not only having the damage to the lungs and so forth but now we're finding out it also causes erosion of the enamel of the teeth. And it's not bad enough that Mountain Dew is dissolving our children's teeth away, now we've got vaping doing it, too.

Ms. ZACHODNI: Do we know if dental providers -there's like a couple of codes where you can do review and education and things like

that, if those are covered codes. I mean, it's just an idea like we're working toward in Indiana because dentists usually see a lot of these populations, too. And if it's an opportunity while they're in the chair, right, and it can be the hygienist or whomever that has that conversation with the teen.

DR. CAUDILL: I don't think that's on the Medicaid fee-for-service fee schedule, although it could possibly be done under EPSDT but that's a prior authorization procedure.

MS. KALRA: That's a great linkage and connection. Do you know what those codes are?

MS. ZACHODNI: D250, one I remember but I don't know for sure.

MS. KALRA: The only reason I ask is when we do get a quorum, it might be something that we could bring up to the MAC.

MS. ZACHODNI: It's just another way of reaching people.

MS. KALRA: Exactly. I mean, like you said, if they're in their mouths already, this is a good way to kind of intersect health and dental together.

Do you guys mind sharing any

handouts or any resources each of your MCOs has to Sharley so that way it could go out to the members? I think that would be helpful because we have several folks not here. That way they have all the information possible.

MS. BEAL: Can you send an official request?

MS. HUGHES: You all can't just----

MS. BEAL: I mean, I can.

MS. HUGHES: Okay. If you can just send it to me, any information you have on the smoking cessation and especially for vaping.

DR. CAUDILL: We do have a tobacco counseling code. That's D1320 in the CDT manual, but, again, that one is not in the Medicaid fee schedule.

MS. KALRA: That's just a helpful tip. Maybe next time we could bring it up and have a more robust conversation around that.

Dr. Caudill, since you're also at the Dental TAC, have they been talking about this at all or this topic?

DR. CAUDILL: It hasn't been on the agenda yet.

MS. KALRA: Has there been dentists around the state that have been interested or need information or anything that you - just what you're hearing on the ground, what folks might need or see?

DR. CAUDILL: Not yet. That article that came out on the erosion and stuff just came out like a few weeks ago. So, it hasn't had time to filter out through the community yet.

MS. KALRA: Okay. I'm just trying to think if there's a way that we could work in tandem with the Dental TAC to share information and jointly make that request, if that would help move things forward. Okay. Thank you.

So, the next order of business is a discussion on requested data from DMS. I know last time when we spoke, we talked about having some sort of data available to us.

I know that Sharley couldn't get all of the data that we've asked for ready for this meeting and I know that she put the request in a month in advance.

So, I guess the question is for you, Sharley, what do we need to do to make sure that we do get data?

MS. HUGHES: We actually, like, late last night and early this morning, we did get some data. There is some question about the data when Commissioner Lee and I looked at it.

So, until we can look at it closer, we did not want to bring it to this meeting, but that data will break down in the age groups of I think it was every five years, like zero to 5, 6 to 10, 10 to 15 and up to 21, and it's going to be the number enrolled and we're going to go back and look at the last either three or four years. I think they gave us from 2016 to 2020.

And also we're going to look at the number of kids by those age brackets and we're going to even look at it from male or female that have received at least one dental visit - and this is cleanings - the ones that have received two cleanings and, then, one that just received like a dental service other than a cleaning, so, like a filling and so forth.

We didn't want to look at just lumping them together because they could have received a dental service and not a cleaning. So, we wanted to look at all three.

We're also looking at the

number of kids by those same age brackets, male/female that have received any type of vision services. In particular, I believe - I think you and I talked a little bit yesterday afternoon that all of them going into kindergarten, I believe, have to have an eye exam. So, we're wanting to see if we're getting that done.

We're also looking at preventive services, same age brackets broken down by male and female and we put the codes in for the preventive services or if they had a diagnosis code or preventive and, then, also the vaccines for children that are in those same age brackets broken down by male or female.

And, like I said, I got all the preventive dental and vision and vaccines late yesterday afternoon. I think some of the numbers look low. So, I had sent it out. I don't want to bring any data to somebody that's not right. So, I've sent it out especially to Lee Guice who is over the KCHIP and all that to get her to glance over it to see if she sees anything.

But, in the meantime, I sent you all out the CMS 416 forms and I printed you all copies today and I've even printed you out the

instructions of what's supposed to be in each of these fields because, quite honestly, I don't know what goes in these fields. Mahak was very familiar with this form when I mentioned the 416. So, you all are probably more familiar with it than I am.

MS. KALRA: These are actually the reports that we used to get every year as the Children's Health TAC and we actually spent time analyzing these time to time and had a presentation from DMS every year to report out where kids slide on to these.

So, going to that point - I'm sorry for cutting you off.

MS. HUGHES: You're fine. We had one that each of the MCOs presented or gave us and, then, there is a combined one that doesn't look quite as nice because we actually pulled it down off of a system and printed it from that. So, it does not look quite as nice and that's the combined all MCOs and fee-for-service.

So, if that helps to get you a start on what we're looking at because I know you all are more interested in the kids because it is the Children's TAC. So, there's that data.

Once we get all this other data

reviewed and provide you all with some summaries, what I'm planning on doing is going ahead and, if it's okay with you all, putting it out on the website, sending it to you all. Then, that way you will have time to evaluate it and see it and we can discuss it at the next meeting.

MS. KALRA: Okay. I think since we're just now getting this and some of the folks haven't had time to analyze it, especially since it was sent yesterday, I think if we could have some time looking through this.

It would be nice to have some sort of presentation from DMS to actually see what----

MS. HUGHES: And that's actually what I plan to do. Our data analytics team does a little summary - they fix it really nicer - it's pretty - the graphs and it will have highlights of the data, like 8% of something or another and 16% is this and what-have-you. So, we'll do that and present it. I'll have more information.

What I've got is they have given me the codes they use. When I looked at it and I'm seeing what I think is low numbers, are we not bringing in all the preventive codes? So, I'm going

to have a list of the codes that you will be able to look at to see what we've actually included in it.

So, we plan on doing a better job. I will tell you. I'm new to doing data for Medicaid. It's not simple because you've got to know what's in that data base thing in order to really be able to pull that data up.

The lady that was pulling the preventive and all that information, she called me late Friday and said I'm going to get it to you Monday. We'll have a discussion Monday morning. Her daughter had a bad wreck on Sunday afternoon and she's out for the week.

MS. KALRA: We understand things come up. I think on our perspective as a TAC, we have been requesting data for over a year now and we haven't consistently even - we actually haven't received any.

MS. HUGHES: You haven't received any data since I've been involved with the TAC. No, you have not.

MS. KALRA: So, I think that's where we are. It gets frustrating because we don't know what to recommend if we don't know where we are. We can't measure anything.

MS. HUGHES: And that's a change in the Administration. The previous Administration did not want to release it. Lisa is the one that says how can we expect them to make recommendations if we don't provide them data. All the TACs are going to start getting data from us.

MS. KALRA: Great. That's very exciting and that's something that we've all been craving and wanting.

MS. HUGHES: And while I'm blabbering, I've also given you all a copy, and there's some extra copies here for anybody, two provider letters that we are sending out today. One is to the waiver providers and basically how they can go about continuing to provide care to the waiver members during the COVID-19 process.

And, then, we have one to all providers where we are waiving the copays, prior authorizations on all this stuff or anything COVID-19-related.

I sent these to you all this morning but I didn't know which of you all traveled the farthest and didn't know if all of you had had a chance to see it. We provided the diagnosis code which is the actual diagnosis, a possible exposure or

an actual exposure.

So, if a Medicaid recipient goes to the doctor and says I think I've been exposed, he can use that diagnosis and submit it and there won't be any copays incurred or anything like that.

So, I just wanted to get you all that information to you today also, and that's being put on our website.

And I provided you the COVID-19 website for Kentucky that's being updated and it's got some good information there. There's actually a link from there to the CDC that goes into a lot of detail about how providers and advocates caring for patients, stuff that they can do to keep themselves safe.

MS. KALRA: That sounds great. Thank you.

Going back to data and I just want to pick your all's brain on what data would we like to see regularly and what data we would like to see annually, knowing that that's been something that we do want but spelling it out for Sharley so that way every single meeting, we at least have something to review and talk about.

So, I have a list of what I thought though, looking back in the previous years that we've had data and seeing what makes the most sense, and I just wanted to run this by you all and see what you all think we need to add to this.

So, number of children enrolled, that's something that we want to see regularly; new enrollees; numbers of disenrollees; enrollment by race, gender and ethnicity.

We used to get an MCO monthly comparison dashboard. I don't know if that's even possible but that's something that we've gotten in the past several years.

MS. HUGHES: What type of data was on that?

MS. KALRA: It was basically a dashboard that had every single MCO and the enrollment numbers, the disenrollment numbers, new enrollees. It also had foster care.

MR. FLYNN: Foster care disenrollment, disenrollment based on address.

MS. KALRA: Yes. We also had appeals and grievances and we did have it broken out in age groups. The age groups were under 1, 1 through 5, 6 through 12 and 13 through 18. And,

then, we did receive the CMS 416 data every year and had a presentation on that.

MS. HUGHES: Was all this other every meeting?

MS. KALRA: Yes. So, all of that was every meeting and, then, the CMS 416 was once a year.

MS. HUGHES: And you want it still just for kids?

MS. KALRA: Yes, up to age 21.

MS. HUGHES: And is this basically still the same data you sent me yesterday afternoon?

MS. KALRA: I think so. I think it might be the same thing that I sent you yesterday but I could double check.

Is there anything else that you all could think of that we would want to see or want data-wise?

MR. FLYNN: I don't think so.

DR. GRIGSBY: Because that's typically what you were getting.

MS. KALRA: Yes. I was just basing it off of the old emails that we used to get and that was helpful because we could then pinpoint

what are the issues and then what are the solutions.

MS. HUGHES: That's why I was wanting to look at like preventive and the dental. We did see even on the 416, you see as they get older, and I don't know personally - I don't have children, so, I don't know personally. Did you see less because there's not as many required services for the older but they still should be going in for at least an annual physical, but we did see and even looking at the 416 that as the age increases, they tend to not go as regularly.

DR. GRIGSBY: The great majority of the visits are in the first three years of life and, then, it sort of tapers off.

DR. CAUDILL: Did you ever look at that data from a POS point-of-view and see if maybe some of the school programs, the mobiles and portables going in are influencing that and they concentrate on the younger kids?

MS. KALRA: We did not.

DR. CAUDILL: You might want to look at it.

MR. FLYNN: What's the question?

DR. CAUDILL: Something that might skew those results is the mobiles and portables

from the dental point-of-view anyway and also vision. They're going in to schools and they concentrate normally on the younger kids. So, therefore, these kids may be seen by these and get more preventive services at a younger age; but as they get older, they're not being seen by these groups and there's quite a few of them throughout the state.

MR. FLYNN: We had some pretty in-depth conversations on that a couple of years ago because my concern was that the dental clinics were coming in doing basic cleanings and the children were getting no followup services based on the findings of those cleanings.

So, if they needed any kind of restorative work, it just wasn't happening because they were checking in, getting the easy, quick cleaning done, sealants done and then they were leaving and, then, those kids had no followup services.

DR. CAUDILL: And that's been changed.

MR. FLYNN: Yes, and that's what I was saying. We talked about that pretty in depth.

DR. CAUDILL: We put some severe criteria in.

MR. FLYNN: And it's been much better since those changes have come around.

MS. HUGHES: And even with the Free Care Rule because now they're going to be able to bill those Medicaid recipients. Even if they don't have an IEP, they can still bill them. So, that will help also with showing more numbers.

MS. KALRA: And as we speak, a Senator is texting me about the Free Care Rule. So, that was a good segway. Great.

So, I think with that list, that might be helpful for Sharley to just make sure that we get that prior to the Children's Health TAC meeting so that way we could analyze on our own and, then, come back here and have a more robust discussion, if that makes sense.

MS. HUGHES: Yes. And like I told you yesterday, once we get them set up, once we get the reports created, then, all I will have to do is go in and just push a button and it re-runs the report. So, after the first time we do them, it won't be a problem with getting them easier.

MS. KALRA: Awesome. And I will send you this again electronically so that way you have that.

MS. HUGHES: I've got your email from yesterday. So, if it's the same, I can go back and look at that.

MS. KALRA: Let me just double check to make sure so that way you have it, and it might be helpful if I just put it in a document for you and not just an email so that you don't have to always search for that email and search for that document.

MS. HUGHES: Okay.

MS. KALRA: Any roundtable updates or concern from professional organizations that we need to think through or discussions that you all have within your organization regarding Medicaid?

DR. CAUDILL: I have something. You were asking about the Dental TAC earlier. We did push through - and this affects children directly - that children in braces can now get a cleaning and fluoride every three months instead of every six.

We were having a problem with orthodontists leaving braces on children too long that were not getting proper PCP care as far as their dentist and their dental home and basically decaying their teeth out to the point that some of these children actually ended up in dentures after they got

their braces off which is horrible.

And I've had to have peer-to-peer meetings with doctors before and say it's better to take the braces off and have crooked teeth than no teeth at all, and their response was kind of, well, yeah, but they've got their one shot here and I was trying to nurse them along and get it done.

I said, yeah, but you can't do that and I didn't want to be bad-mouthed and be the bad guy that took the braces off.

So, in our TAC meeting, Heather Wise headed up our committee and she and I pushed it through to kind of, number one, give the doctors an out by saying these are the clinical guidelines we recommend now as a committee so that the doctors could point to this and say, okay, you have three strikes and you're out.

If they come back for three visits and plaque is everywhere, decay, white spots, the teeth are basically rotting, we're going to take the braces off and stop.

And that gives the doctors an out, number one, and, then, number two, under EPSDT which also gives us increased frequency, we can now cover that extra prophy and extra fluoride treatment

- not an extra exam, but cleaning and fluoride every three months because we feel it is medically necessary to do that if they've got braces on their teeth which makes it much more difficult to clean their teeth and a much higher chance of decay.

So, we did get that pushed through, and speaking for Guardian and Avesis, our four plans did that and, then, finally DentaQuest came on board with Anthem and they agreed to do it also. So, all five plans are doing it now.

MS. KALRA: Great. That's excellent. Do you mind sharing that, whether if it's a guidance letter or whatever you all have.

DR. CAUDILL: It was a recommendation from the TAC to the MAC but we all went ahead and instituted it.

MS. KALRA: Okay. It would be good to have that.

DR. CAUDILL: Because under EPSDT, we look at it for medical necessity, and if it meets that criteria, we're going to approve it.

MS. KALRA: Okay. Great. That should definitely be sent out to folks who are a part of the Children's TAC.

I don't know if others have any

information?

DR. GRIGSBY: I reached out and neither the Executive Director nor the president really could think of anything that was pressing that we needed to discuss right now.

MR. FLYNN: Nothing here.

MS. KALRA: Sounds good. On that note, Old Business.

MS. HUGHES: You missed a couple.

MS. KALRA: Oh, what did I miss? Sorry. Topics for 2020. We have other topic ideas - CBD, vaccines, school safety.

I wonder if we should continue the conversation on vaping just because we do have some sort of action item, knowing that the Medicaid fee schedule, adding the D1320 to that, that could be a recommendation. And, then, also, we could have a more robust conversation about either of these three topics.

So, I don't know if you guys have a preference.

MR. FLYNN: I don't have a preference.

DR. GRIGSBY: No. I think

vaping is going to be something that unfortunately we're going to be dealing with for a little while.

MS. KALRA: So, maybe we could at the next meeting have a more robust conversation about what other ways can we attack this problem that are administrative policies, look at that.

And hopefully by that time, we will have more folks in the room and, then, also have the presentations out to them that they could read and at least follow up with to be more well aware of this situation. So, we'll have that as a conversation.

Updates on the MAC. I did not attend the MAC because that was our Advocacy Day, as I told you. So, I don't know if there is anything.

MS. HUGHES: That seems like it's been a long time ago because I took a week's vacation during that time.

I don't think there was a lot. Rather than the TACs making their comments at the meeting coming up on the 26th, if it's continued to be held, we are going to have - I think this is the one where we have it's either two or three of the MCOs will be doing a presentation, one in May and the rest of them will do a presentation.

We are going to start doing small presentations to each of the TACs where you have in writing the highlights of what's going on in the Department. So, we're going to start that up.

At the meeting, Lisa was there and had been there maybe three or four days, and there's really not been a lot of changes, negative changes since the new Administration came in.

There's been some positives such as providing data and being more transparent. So, I think going forward, at least for the next few years, we should be doing a little bit better of being more transparent and providing more information.

The next MAC meeting was scheduled to be held here at Public Health. I received notification that that conference room, we've been booted out.

So, I am now in the process of trying to find another room. The Annex was not available. That's why we were meeting over here. This room is now being used for nothing but COVID-19 meetings with Public Health. So, they don't want anybody scheduled there.

So, I am going to go meet

someone at the Bluegrass Community Action Agency Partnership which is, if you go past Cracker Barrel out here on Versailles Road and go back in through there. I'll send everybody the address if that's where it will be held, but just be aware that the location is probably going to change for the MAC meeting.

MS. KALRA: Just for the upcoming meeting.

MS. HUGHES: Just for the upcoming meeting. And be aware that at anytime, it could also be cancelled, depending upon COVID-19 as well.

MS. KALRA: Okay. Sounds good. Great. Thank you. We did the roundtable updates.

Old Business. I wanted Alicia here with KYA, my colleague, to talk about what she has dug into Free Care. This was actually a part of her internship and it's something that she dug into, learned about best practices.

So, I'm going to let you all hear from her for a minute because you guys are the on-the-ground folks that will probably see this implement and she has learned some great best practices from across the state.

MS. WHATLEY: So, like Mahak said, my name is Alicia Whatley. I am now with Kentucky Youth Advocates but I'm also working on a master's in social work, so, I'm also in school and doing some projects for that.

So, this is just a document that I put together with some of my research that I've done about Free Care. So, I have looked into a few different things regarding the history of why Free Care is now available, Kentucky going ahead and getting that approved and, then, looking at literature about outcomes that we can expect for kids, if we are implementing Free Care correctly in schools, talking to stakeholders across the state that are interested in this and that have been involved in the planning process and kind of their perspective and, then, also looking into other states that have already implemented and how they're doing it and how they're getting information out in the state.

So, there is a time line up in the top left there that kind of tells you when federally this became available. It was back in 2014. In April of 2019, Kentucky submitted their State Plan Amendment asking to be able to provide

Free Care in schools and that was approved in November but it was backdated to August 1st.

So, everyone should probably already know that but just a refresher. There's also an explanation of what Free Care is here if you don't know a lot about it, but it's expanding services, health care services that can be provided in the schools, like Sharley mentioned, beyond just those IEP kids that have those plans.

So, now, any kid receiving Medicaid can receive services in school and a licensed provider can bill for that.

I do think it's important to circle back to why it's really important in Kentucky to have Free Care. So, there are some rankings here nationally. Kentucky in health is 25th in the nation, education 27th and overall child well-being we're 34th.

So, obviously we can see there's some room for improvement in all of those categories, and we think that the Free Care Rule will have the potential to impact all of these numbers and hopefully move us up in some of those rankings as a state.

And, then, there's also an

explanation of some of the outcomes that have been found in other states and in the literature about what health care in schools can do for kids.

So, one thing that we know is that, yes, their health outcomes might improve and we might see, like, less risk behaviors. We might see improvements in specific health conditions, understanding of their own treatment. So, things like asthma or diabetes that are chronic needs that they continuously have to take care of, kids might understand that better and be able to help their own treatment, but, in addition, we also see academic outcomes.

So, it's really important to note that those are linked and that if kids are not healthy, they're not learning. And, so, it's really important to get then healthy before they're able to learn optimally in school.

Like I said, I have looked at other states as well. A couple of states that have put out really nice toolkits that are available online - Ohio, Michigan, Colorado and Massachusetts - and there's pretty wide range all over the country that have been doing this.

So, from that research, talking

to a lot of stakeholders across the State of Kentucky, I've come up with some recommendations which are on the back there of what needs to happen from here on out. Some of these things are already happening to some extent and some of these just need to be expanded on.

So, the biggest thing is communication among the main players in a state that are implementing this. So, the bare minimum is going to be the Cabinet for Health and Family Services, DMS and, then, KDE. Those bodies are already talking to each other but they need to be continuously talking and implementing things together.

And, so, instead of having pieces of information coming from each body, we need to just have like comprehensive information that's coming together. That's going to be really important because a lot of people across the state are going to who they know for information.

And, so, if we're not having the same information from each person, then, it's going to be very confusing and hard to implement.

One consideration that I think we should be looking at is having like one landing page on the Internet for all of this information to

be. So, whether it's linked on all three of those people's websites or however that might look, but instead of each of them having random pieces of information about Free Care on their websites, we need to have one comprehensive place that people can go for information.

I know that they have been working on some like technical assistance guides and things like that. So, having that in one place and, then, just having everybody direct to the same location for that.

Another note is that those three bodies that I mentioned are kind of the bare minimum. There might be other people that need to be brought in. An example of that is entities that are vendors for billing within schools now. So, there are vendors that are helping with billing for the kids that have IEPs in all the public schools.

So, those people might need to be brought to the table as well. So, that's going to be up to those three bodies of who they need more expertise from and more answers from. So, that's the first two things there.

The next thing is going to be ongoing support. So, some of the themes that I found

from my interviews is that there's going to be a lot of questions. There already are a lot of questions that have not been answered, so, specifically about Medicaid processes and billing because schools are going to be implementing new billing procedures.

So, somebody is already billing Medicaid in almost every public school because kids on an IEP are using that system; but if we're expanding to so many more students, the schools might need to put in new positions of people that are helping with those billing procedures or new practitioners in a lot of cases.

And, so, there might be some need for support around that, around the training of their current people that are in place, around changes that are going to happen and processes in the school.

There's been a lot of questions about HIPAA regulations for the health pieces but also FERPA within the schools and how do those interact, how can those talk to each other or not talk to each other in some cases. And, so, there needs to be some guidance around that.

I've seen other states do a really good job of explaining some of the legalities

that go into that. Colorado has a great guide about how HIPAA and FERPA are different but also how they can work together to work inside school systems.

And, then, another big issue or a concern that I've heard is continuity of care for students. So, this needs to be thought about before we start providing care. If kids are getting care in the schools, what happens when they go home and who is that provider?

So, if you're seeing, for instance, when we talk about mental health care in the schools, if you see your therapist at school and that's consistent, that's great, but, like, you go home. You have weekends. You have breaks. You have summer. You might be out of school for COVID-19. Like, there's times when you're not in that school building.

And, so, it's a question of who is that person that you're going to go to when you have a crisis when you're not at school?

So, making sure that we maybe think about that before we hop in and start addressing these concerns for the kids is knowing who they can go to when they're out of school and, then, understanding there are a lot of regulations around

how many providers you can see in a day when you're billing Medicaid.

So, knowing if we are at school seeing one provider, can they also see another provider and where that is going to lie, kind of defining all that out and that's going to be something that people are going to have ongoing questions about.

So, we need to have a really clear path of support for schools to be able to go and say, like, I need help with this and knowing who they can go to.

In addition, I think that any information that goes out, it's helpful to target it to certain people. So, saying here is information that's for district professionals, here's information that's for school faculty or teachers to understand it better, here's information for your parents to understand what's going to happen in the schools and, then, here is a provider version of what we're putting out, so, kind of targeting to different audiences so that everyone is getting the information that they need, and that might look different for different professionals in the school system.

And, then, finally, I think the

evaluation is going to be really important. So, this is very new to Kentucky. This is something that's going to be changing and hopefully growing over time. So, continuing to reconvene those three main bodies and anybody that they are drawing on for support and continuing to have those meetings.

Instead of saying, okay, we've now implemented, we're done, we need to be coming back together on a consistent basis and saying like how are we doing, how is it working, what are the outcomes and, then, improving upon that every time that we're able to come together and talk about it.

So, that's just a quick overview of a lot of research that I have been doing and a lot of things that I've looked into.

A lot of people in the room are probably pretty familiar with the Free Care process hopefully and what's going to be coming. Does anyone have questions?

DR. GRIGSBY: I know this is a ton of work that you've done over many months all on two pages.

MS. WHATLEY: It was, yes. It's hard to fit it all in sometimes.

DR. GRIGSBY: So, thank you for

that. That's a very nice summary.

MS. WHATLEY: Thanks.

MS. KALRA: Awesome. Thank you. So, we don't have any data requests or reporting or questions. I don't know if the MCOs have updates. I know we didn't request anything. So, if you guys have something that you are burning to say. That looks like a no.

I think general governance we kind of talked about having more members engaged and involved earlier.

Is there any other business? I guess we will adjourn. Thank you.

MEETING ADJOURNED